

# **KETAMINE ASSISTED PSYCHOTHERAPY**

## **INFORMED CONSENT FOR SERVICES**

### **Polaris Insight Center - A Psychological Corporation**

Welcome to Polaris Insight Center!

Polaris Insight Center's mission is to offer cutting edge, innovative mental health treatment for individuals suffering from a wide variety of psychological conditions as well as to provide services for those seeking personal growth, development, and self-actualization.

It is very important to us that all patients feel **welcomed, safe, supported, and respected**, and we will address any concerns that might arise in this regard.

Polaris Insight Center providers include physicians, psychologists, and marriage and family therapists. We are governed by certain laws and regulations and by a code of ethics. The ethics code requires that we make you aware of certain office policies that may affect you. Please take time to read this document as it contains important information about our professional services and business policies. It is also highly recommended for all prospective patients to read through the information on our website and the more detailed descriptions of ketamine's potential and properties as a medication, as well as the more detailed descriptions of ketamine assisted psychotherapy (KAP). Please feel free to ask any questions that arise. **By signing this agreement you agree and acknowledge that you have read and understand our Ketamine Information Package and any question and/or concerns you have regarding the services or this agreement have been answered and resolved to your satisfaction.**

### **Ketamine Assisted Psychotherapy**

Ketamine assisted psychotherapy (KAP) is a relatively new and innovative psychiatric/psychological treatment approach, involving the combination of ketamine administration in a safe and supportive "set and setting," inner-directed and supportive psychotherapy, and ongoing integration.

The exact nature of the treatment process varies depending on the particular problems being treated and the specific individual's needs and goals; we firmly believe in finding the most optimal way to support an individual's' growth, healing, and personal evolution.

Initial sessions will involve an evaluation of a patient's: current problems, concerns, and needs; prior history and review of current or ongoing treatment; overall health/medical condition; and an assessment of the potential suitability and viability of this type of treatment for that patient. By the end of the evaluation period, we will offer our clinical impressions and a recommended approach to treatment. The goals of therapy are always arrived at by **mutual collaboration**. These goals will be reviewed during the course of the treatment in order to assess and/or modify them according to changing needs, perspectives, and progress. Participation in this treatment may result in a number of benefits but there is no guarantee that this will occur.

During this assessment phase, it is important that we carefully consider whether or not we are the best provider of ketamine-related services, and if Ketamine Assisted Psychotherapy is the best approach for an individual's specific situation. If indicated, a referral to a more appropriate provider will be recommended.

As with all medical and psychiatric care, including psychotherapy, there are both risks and benefits to pursuing treatment. Psychiatric care and psychotherapy are not exact sciences. There are no guarantees made as to the result of such examinations, treatments, and/or diagnostic procedures.

When receiving treatment patients may sometimes find they **feel worse before feeling better**. KAP is a non-linear treatment process and individual responses vary widely. If any questions or concerns about our work together arise at any point during treatment, please bring them to our attention.

### **Voluntary Nature of Participation**

Your decision to undertake Ketamine Assisted Psychotherapy is completely voluntary. Your signature of the consent to treatment indicates that you have understood the benefits and risks of this treatment.

### **Confidentiality**

**Confidentiality is a foundation of the treatment in Polaris Insight Center.** The ethical standards of our profession require that our work remains strictly confidential

with certain limits. This means that we cannot reveal any information about our patients, either verbally or in writing, to any other person or agency without specific written permission. There are certain situations in which we are required by law to reveal information obtained during therapy to other persons and agencies without a patient's permission. These situations include:

- **Child Abuse or Elder Abuse:** we are mandated by law to report cases of suspected abuse or neglect of a child (anyone under age 18), dependent adult, or elderly person (adults over age 65) to the appropriate authorities.
- **Suicide:** If a patient is in imminent danger of seriously hurting or killing him/herself, we may need to breach confidentiality in order to keep you safe. This may include informing friend(s), family member(s), doctor, or the appropriate law enforcement agencies that could aid in providing protection, safety, and other helpful forms of immediate treatment.
- **Homicide:** If a patient threatens serious bodily harm or death to another person, we are required by law to inform the appropriate law enforcement agencies, to inform the intended victim(s), and to inform any other necessary individuals in order to prevent loss of life.

**As Mandated by Law:** For example, if we receive a subpoena, we may be required to submit your records as part of a legal proceeding.

These situations are relatively rare, but if similar situation occurs in your case, we **will make every effort to discuss it with you fully before taking any action.** At times, therapy may involve the participation of more than one family member and/or significant person(s). We will attempt to follow the patient's wishes, but we can not guarantee confidentiality among participants in the family or couples therapy.

### **Psychotherapy Consultation, Records Keeping, and Recording of sessions**

Professional consultation is an important component of medical and psychotherapy practice. In order to provide the best possible treatment for you we regularly participate in clinical, ethical, and legal consultation and training with appropriate professionals. During such consultations we might talk about the content of our work together, but we will not reveal any personally identifying client information without an individual's written permission. We as well collect data measures to track your progress in therapy and we might use this data anonymously in research data collection for efficiency of KAP.

The laws and standards of our profession require that we keep treatment records. **These may include information about patient's diagnosis, therapy goals, progress in treatment, documentation of mandated disclosures, and other information.** All

patients have a right to view their records or receive a treatment summary, unless doing so would be likely to cause substantial harm, endanger a patient's life or physical safety, or pose a significant risk of harm to another individual.

### **Cancellation Policy:**

The scheduling of an appointment involves the reservation of time specifically for you. In order for therapy to be effective, it is important you commit to that time. If you are unable to attend your scheduled appointment, patients must **call 48 hours** in advance or they will be charged **a full appointment fee**. The appointment may be considered cancelled if a patient arrives more than 15 minutes after the scheduled appointment time. Patients will be asked to keep a credit card on file and this will be charged for missed appointments without prior approval.

### **Professional Fees**

Ketamine Assisted Psychotherapy is an **investment in you, your relationships, your family, and your life**. Our fee is established by a combination of our education, knowledge, experience, expertise and time.

### **Our agreed upon fees are:**

#### **Treatment Package 1 - \$2450**

(Medical and Psychological Evaluation, 2 in-office Lozenge dosing sessions, prescription and email support for 4-at-home Lozenge dosing sessions, end of treatment call evaluation and support)

#### **Treatment Package 2 - \$4750**

(Medical and Psychological Evaluation, 6 in-office Lozenge dosing sessions, end of treatment call evaluation and support)

**90- minute medical and psychological evaluation session with treatment provider team - \$450**

**Booster Lozenge dosing session - \$700**

**Booster Intramuscular dosing session - \$1000**

**Medication refill and monitoring \$150/4-sessions**

**We reserve the right to periodically adjust our fees and you will be notified of any fee adjustment at least 2 weeks prior.**

From time-to-time, we may engage in telephone contact with you for purposes other than scheduling sessions. You are responsible for payment of the agreed upon fee (on a pro rata basis) for any **telephone calls longer than fifteen minutes**. In addition, we may engage in telephone contact with third parties at your request. You are responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than fifteen minutes. You are responsible for payment of the agreed upon fee (on a pro rata basis) for email exchanges that will take provider longer than 10 minutes.

Payments are required at the time of your appointment, unless other arrangements have been made in advance. **If at any point in the course of treatment you are unable to pay your bill, please discuss with us as soon as possible.**

If your personal check is returned for insufficient funds you will be charged a \$50 fee.

Outstanding balances that remain unpaid for more than 15 days are subject to interest at a rate equal to 25% per annum of such outstanding balance. We have the option of using legal means to secure payment, including the use of collections agencies or small claims court. If such legal action is necessary, the costs of such proceedings will be included in the claim. In most cases the only information released about a client in such a process would be the client's name, the nature of the services provided, and the amount due.

### **Termination of Treatment**

You have the right to end treatment at any time without any moral, legal or financial obligation other than those already accrued. And if you wish, we will provide you with referrals to other qualified professionals.

We, too, reserve the right to terminate treatment at our discretion. Reasons for termination include, but are not limited to, untimely payment of fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in treatment, client needs are outside of our scope of competence or practice, or lack of adequate progress in treatment.

### **Contacting the Center**

Although we might not be always available immediately by phone, you can leave us a voicemail anytime at **415-800-7083**. We check voicemail on a regular basis. We will make every effort to return your call on the same day, or by the next business day at the very latest, with the exception of weekends, holidays, and periods that we have pre-arranged to be out of town. If you have an emergency, call San Francisco Crisis Line **415-781-0500** (1-800-273-8255), dial **911**, or proceed to your nearest emergency room.

### **Electronic Communication**

It is important to be aware that email, text and fax communications can be relatively easy to access by unauthorized people which can compromise your privacy and confidentiality. We do not have email encryption capabilities. **If you choose to communicate confidential information to us via email, text or fax we will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication may be intercepted.** Be aware that emails and text messages are part of the official medical record. **Please do not use email or text messages to communicate emergencies.**

**I agree with below indicated communication with Polaris Insight Center**

Cell phone	Y/N	it is ok to leave a message	Y/N
Home phone	Y/N	it is ok to leave a message	Y/N
Work phone	Y/N	it is ok to leave a message	Y/N
Text - SMS	Y/N		
Email	Y/N		

### **Acknowledgement**

**By signing below you are acknowledging that you have reviewed and fully understand the terms and conditions of this agreement and that you have discussed any questions. You agree to hold Polaris Insight Center free and harmless from any claims, demand or suits for damages from any injury or complications whatsoever, except for gross negligence or willful misconduct that may result from such treatment.**

Your signature indicates that you have either received a copy of this agreement in person or by email, or have waived the right to receive a copy at your own insistence.

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Signature of Client

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Printed Name of Client and Date

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Signature of Polaris Center Therapist

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Printed Name of Polaris Center Therapist and Date